Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 16, 2016	2016_263524_0017	012774-16	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée

McGARRELL PLACE
355 McGarrell Drive LONDON ON N6G 0B1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

INA REYNOLDS (524)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 11, 12, 2016.

This Critical Incident inspection #2964-000012-16 was related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Associate Director of Care and the Program Manager.

The Inspector also reviewed the critical incident, resident clinical records, and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the 24-hour admission care plan included, at a minimum, the following with respect to the resident: any risks the resident may have posed to himself or herself, including risk of falling, and interventions to mitigate those risks; any risks the resident may have posed to others, including potential behavioural triggers, and safety measures to mitigate those risks; and, the type and level of assistance required related to activities of daily living.

An identified resident was admitted to the home on a specific date. Record review of the progress notes indicated that the resident was assessed by a physiotherapist at the time of admission to be at high risk for falls. Record review of the Side Rail and Alternative Equipment Decision Tree document noted that the resident would attempt to get out of bed unsafely. Falls interventions were noted in the progress notes to mitigate those risks.

Record review of the Community Care Access Center (CCAC) Assessment, the Minimum Data Set (MDS) Assessment, the hard copy of the Resident Admission Assessment and progress notes indicated that the identified resident had numerous responsive behaviours. Progress notes and assessments further noted the resident would be at high risk to injure self and others and was dependent on staff for personal care needs.

Record review demonstrated there was no documented evidence to support that a 24-hour care plan was developed for the resident and communicated to direct care staff. The Administrator agreed there was an absence of a 24-hour care plan. [s. 24. (2) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the 24-hour admission care plan includes, at a minimum, the following with respect to the resident: any risks the resident may pose to himself or herself, including risk of falling, and interventions to mitigate those risks; any risks the resident may pose to others, including potential behavioural triggers, and safety measures to mitigate those risks; and, the type and level of assistance required relating to activities of daily living, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any action taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions were documented.

A) Record review revealed the home initiated a monitoring record for an identified resident on an identified date, in specific time intervals. Review of the monitoring record for the identified time frame, revealed that staff did not always document these observations.

Interview with the Administrator and the Director of Care agreed that the observations were not always documented.

B) Record review of the admission progress notes, revealed an identified resident was at high risk to injure self and others related to a specific unsafe behaviour. The admission plan in the progress note directed all shifts to monitor the resident at specific time intervals for the unsafe behaviour. Review of the monitoring chart revealed an absence of documentation in the specific time intervals related to the resident's unsafe behaviour.

The Administrator agreed there was an absence of documentation related to the identified resident's unsafe behaviour on the monitoring record. [s. 30. (2)]

Issued on this 21st day of June, 2016

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.